

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/21/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175532	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/21/2015
NAME OF PROVIDER OR SUPPLIER AVITA HEALTH AND REHAB AT REEDS COVE			STREET ADDRESS, CITY, STATE, ZIP CODE 2114 N 127TH CT EAST WICHITA, KS 67228		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS	F 000			
F 309 SS=D	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>The following citations represent the finding of a Health Resurvey and Complaint Investigation #75206, #75819, #76106, #77685, #81079, #81551, and #86315.</p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: The facility census totaled 69 residents with 27 in the sample with 1 resident reviewed for dialysis. Based on observation, interview and record review the facility failed to ensure staff provided necessary care and services (provision of therapeutic diet and fluid restriction, monitoring and assessment of the resident's shunt (access site used for dialysis), and thoroughly assess the resident, including vital signs after returning to the facility from dialysis) for 1 resident reviewed for dialysis. (#97).</p> <p>Findings included:</p> <ul style="list-style-type: none"> - Review of resident #97's signed physician orders dated 5/5/15 revealed the following diagnoses: atrial fibrillation (rapid heartbeat), end stage renal disease (inability of the kidneys to excrete wastes, concentrate urine and conserve 	F 309			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/21/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175532	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/21/2015
NAME OF PROVIDER OR SUPPLIER AVITA HEALTH AND REHAB AT REEDS COVE			STREET ADDRESS, CITY, STATE, ZIP CODE 2114 N 127TH CT EAST WICHITA, KS 67228		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 309	<p>Continued From page 1</p> <p>electrolytes), diabetes mellitus (when the body cannot use glucose), and congestive heart failure (a condition with low heart output and body becomes congested with fluid).</p> <p>Review of the annual MDS (minimum data set) dated 3/22/15 revealed a BIMS (brief interview for mental status) score of 13 indicating normal cognition. The resident required extensive assistance of one staff for bed mobility, transfers and toilet use. The resident was occasionally incontinent and received a therapeutic diet. Medications included insulin injections 7 days of the 7 day look back period. The resident received dialysis 3 times a week for end stage renal failure.</p> <p>Resident #97's 1/21/15 Nutrition CAA (care area assessment) indicated the resident was at risk for nutritional issues and received a specialized 1800 calorie ADA (American Diabetic Association) diet. The CAA also stated the dietician monitored the resident monthly and as needed.</p> <p>Review of the care plan with a date of 5/5/15 revealed: The resident needed hemodialysis due to renal insufficiency related to chronic renal disease.</p> <p>Approaches included;</p> <ul style="list-style-type: none"> * 1200mL/day (milliliters per day) fluid restriction, resident non-compliant with fluid restriction and signed a risk/benefit form located on the chart. * Resident will be reminded the importance of compliance with treatment plan, fluid restrictions, dietary restrictions, energy conservation, importance of compliance with medications and dialysis treatment. * Please, communicate with dialysis unit for any changes in weight or medication orders. Send 	F 309			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/21/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175532	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/21/2015
NAME OF PROVIDER OR SUPPLIER AVITA HEALTH AND REHAB AT REEDS COVE			STREET ADDRESS, CITY, STATE, ZIP CODE 2114 N 127TH CT EAST WICHITA, KS 67228		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 309	<p>Continued From page 2</p> <p>dialysis communication form each time the resident goes to dialysis and ensure that it comes back with resident.</p> <ul style="list-style-type: none"> * Ensure documentation of the pre and post dialysis weights, assessment of the shunt, labs drawn including results, any complication or change in condition while at dialysis, meal and fluids intake, condition of dressing and time applied and vital signs (non-invasive tests done by nursing staff to check the resident's well-being). * Registered Dietician to work in conjunction with Dialysis Dietician to regulate diet. * Assess and palpate for thrill and auscultate for bruit every shift. Notify physician immediately if thrill or bruit is absent. Also, assess for bleeding every shift. * Do not draw blood or take blood pressure in the left arm, no venipunctures (needle into vein to draw blood), or finger sticks to be done on the left arm. * Resident should not wear tight clothing on the left arm. Apply cover dressing or cover with plastic dressing on the AV Fistula site (shunt) prior to showers. If dressing on the fistula area gets wet, notify the nurse immediately. * Resident to be monitored for signs and symptoms of renal insufficiency: Changes in level of consciousness, peripheral edema (swelling), changes in skin turgor (elasticity), oral mucosa, changes in heart and lung sounds. Notify physician if resident experiences symptomatic hypotension (low blood pressure): Place resident in a Trendelenburg (head down and legs elevated) position immediately as indicated. * Resident to go to dialysis on Tuesday, Thursday and Saturday, at 11:30 a.m. per dialysis schedule. 	F 309			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/21/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175532	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/21/2015
NAME OF PROVIDER OR SUPPLIER AVITA HEALTH AND REHAB AT REEDS COVE			STREET ADDRESS, CITY, STATE, ZIP CODE 2114 N 127TH CT EAST WICHITA, KS 67228		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 309	<p>Continued From page 3</p> <p>Review of the physician orders dated 3/5/15 revealed an order for an 1800 calorie diet.</p> <p>Review of the physician orders dated 3/5/15 revealed an order to resume all pre-hospital orders which included a renal diet.</p> <p>Review of the physician orders dated 5/5/15 had no order for the nursing staff to check for thrill (vibration from blood through shunt) or bruit (swishing sound heard with stethoscope over the shunt).</p> <p>Review of the medication records form 3/5/15 to present lacked documentation that the nursing staff monitored the fistula every shift and when returning from dialysis.</p> <p>Review of the physician orders dated 3/5/15 revealed the resident was to be on a 1200cc (cubic centimeter) every 24 hour fluid restriction.</p> <p>Review of the daily fluid input sheets for 5/2/15, 4/30/15, 4/24/15, 4/23/15 and 5/3/15 revealed the sheets not completed. The clinical record only included fluid intake sheets for the above listed dates.</p> <p>Observation on 5/13/15 at 7:15 a.m. revealed the resident sat at the dining table and biscuits and gravy and a sausage patty. The resident had a cup of coffee and a glass of water. Dietary staff gave the resident another cup of coffee per resident request. A large discolored area was present to the left upper arm (location of the resident's shunt).</p> <p>Observation on 5/13/15 at 4:10 p.m. revealed the resident returned from dialysis. A large dressing</p>	F 309			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/21/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175532	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/21/2015
NAME OF PROVIDER OR SUPPLIER AVITA HEALTH AND REHAB AT REEDS COVE			STREET ADDRESS, CITY, STATE, ZIP CODE 2114 N 127TH CT EAST WICHITA, KS 67228		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 309	<p>Continued From page 4</p> <p>was visible on the upper left arm. Direct care staff G took the resident to his/her room and offered the resident a snack and something to drink. No further assessments were done at that time.</p> <p>Observation on 5/13/15 at 4:15 p.m. revealed licensed nurse K entered the resident's room. The nurse asked the resident for the paper work from dialysis. The resident gave the nurse a white envelope with paper inside the envelope and the nurse exited the room. No further evaluation was done at that time.</p> <p>During an interview on 5/14/15 at 12:30 p.m. the resident stated dialysis really wore him/her out and the resident just wanted to rest when he/she returned from dialysis. The resident also stated he/she would often times just eat supper in his/her room on dialysis days.</p> <p>During an interview on 5/13/15 at 8:00 a.m. direct care staff D reported knowing the resident was on a 1200 cc fluid restriction but did not know who gave the resident what fluids or how much.</p> <p>During an interview on 5/13/15 at 8:15 a.m. dietary staff F reported the resident was on an 1800cc fluid restriction and only received a cup of coffee with breakfast.</p> <p>During an interview on 5/13/15 at 8:20 a.m., direct care staff E reported he/she did not know about the resident's fluid restriction. Staff E reported not working the hall very often and floated between houses.</p> <p>During an interview on 3/13/15 at 3:30 p.m., licensed nurse K reported staff wrote the resident's fluid intake on a sheet in the resident's</p>	F 309			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/21/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175532	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/21/2015
NAME OF PROVIDER OR SUPPLIER AVITA HEALTH AND REHAB AT REEDS COVE			STREET ADDRESS, CITY, STATE, ZIP CODE 2114 N 127TH CT EAST WICHITA, KS 67228		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 309	<p>Continued From page 5</p> <p>room and at the end of the day, staff put the forms in a tray at the nurse's station. The night staff put the forms into the resident's record. The nurse was not aware of the missing, incomplete intake sheets.</p> <p>During an interview on 5/13/15 at 4:30 p.m. direct care staff G reported that when the resident returned he/she would offer the toilet, check the resident's fluids and get the resident a snack. The staff did not know what to do if the resident had an emergency he/she stated he/she would go report to the nurse.</p> <p>During an interview on 5/14/15 at 7:10 a.m. direct care staff H reported he/she did not know what kind of diet the resident received.</p> <p>During an interview on 5/14/15 at 7:12 a.m. direct care staff I reported being newly employed and did not know what diets the residents received or what he/she needed to monitor for the resident's on dialysis.</p> <p>During an interview on 5/14/15 at 8:30 a.m. dietary staff F reported having a list of what the resident could not have while being on dialysis and a renal diet. The list included all foods the resident could not have but the staff reported in the morning the resident had his/her favorites such as biscuits and gravy and refused to give that up so dietary staff F gave the resident just 1/2 biscuit and that satisfied the resident.</p> <p>During an interview on 5/14/15 at 7:25 a.m. licensed nurse K reported the resident was on an 1800 calorie diet but relied on the dietary staff to serve the right diet. Nurse K did not monitor the resident's diet. Nurse K also reported he/she did</p>	F 309			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/21/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175532	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/21/2015
NAME OF PROVIDER OR SUPPLIER AVITA HEALTH AND REHAB AT REEDS COVE			STREET ADDRESS, CITY, STATE, ZIP CODE 2114 N 127TH CT EAST WICHITA, KS 67228		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 309	<p>Continued From page 6</p> <p>not know who updated the care plan when the resident had a diet change. When the resident returned from dialysis nurse K checked the resident's paperwork from dialysis and checked the resident's fluids. The nurse did not mention checking the site for bleeding nor checking the resident's fistula for bruit and thrill, or any emergency measures should an emergency arise.</p> <p>During an interview on 5/14/15 at 8:10 a.m. administrative staff L reported the diet on the care plan (renal diet) was the correct diet for this resident. When the resident readmitted from the hospital in March the 1800 calorie diet was on the readmission orders but the physician wrote an order to resume all pre-hospital orders so the resident should have been on a renal diet not the 1800 calorie diet.</p> <p>During an interview on 5/14/15 at 4:45 p.m. administrative nurse B reported he/she expected the nurse on duty should know what to monitor for when a resident returned from the dialysis center. The staff should also know the special diets of dialysis residents to ensure the resident was receiving the right foods for his/her diagnosis.</p> <p>Review of the policy named Hemo-Dialysis revealed it was the policy of the facility to provide excellence in care and services to residents with End Stage Renal Disease receiving hemo-dialysis at a certified renal dialysis center off site.</p> <p>Review of a facility policy named Fluid Restricted Diets. The purpose is to ensure that fluid restrictions ordered by the physician are carried out by the Nursing and dietary departments.</p>	F 309			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/21/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175532	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/21/2015
NAME OF PROVIDER OR SUPPLIER AVITA HEALTH AND REHAB AT REEDS COVE			STREET ADDRESS, CITY, STATE, ZIP CODE 2114 N 127TH CT EAST WICHITA, KS 67228		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 309	Continued From page 7 Nursing can record the resident's consumption of fluids during meals; medications pass, and free fluid using the facility input and output documentation. Both certified nurse aides and dietary should review fluid restrictions to make sure that allotted amounts are not exceeded. The facility failed to ensure resident #97 received a renal diet as ordered and monitor his/her fluid restriction. The facility also failed to ensure licensed nursing staff assessed the resident's shunt for thrill/bruit and failed to thoroughly assess the resident upon return to the facility from dialysis.	F 309			
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: The facility census totaled 69 residents with 27 residents sampled, and 5 reviewed for accidents. Based on observation, interview, and record review the facility failed to ensure staff followed the care plan for 1 of 5 residents to prevent a fall for resident # 22 which resulted in a fractured pelvis. Findings included:	F 323			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/21/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175532	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/21/2015
NAME OF PROVIDER OR SUPPLIER AVITA HEALTH AND REHAB AT REEDS COVE			STREET ADDRESS, CITY, STATE, ZIP CODE 2114 N 127TH CT EAST WICHITA, KS 67228		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 323	<p>Continued From page 8</p> <p>- Review of resident #22's physician order sheet dated 5/5/15 included the following diagnoses: urinary tract infection, muscle weakness, and history of falls.</p> <p>Review of the admission MDS (minimum data set, a required assessment) dated 2/4/14 revealed the resident had a BIMS (Brief interview for mental status) score of 14 (cognitively intact). The MDS also revealed the resident needed total assistance of 2 staff for bed mobility and transfers, and extensive assistance of 2 for toileting. The MDS identified the resident did not walk during the previous 7 days. According to the assessment the resident had a fall within the past month prior to the assessment, but none since admission to the facility.</p> <p>Review of the ADL CAA (care area assessment) dated 2/5/14 revealed the resident was admitted to the facility after being in the hospital for a UTI (urinary tract infection) and weakness. The resident needed extensive assistance of 2 staff for most ADLs (activities of daily living). The resident used a wheelchair and walker for transfers and short distance like from bed to wheelchair. The resident required extensive assistance of 1 staff to propel the wheelchair. The resident had weakness and required total assist with transfers and bed mobility of 2 staff.</p> <p>Review of the Fall CAA dated 2/5/14 identified the resident at risk for falls due to the resident unaware of safety needs, weakness, impaired mobility and pain. It revealed the resident had not fallen at the facility but did have an unsteady gait and history of falls at home.</p> <p>Review of the significant change MDS dated</p>	F 323			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/21/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175532	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/21/2015
NAME OF PROVIDER OR SUPPLIER AVITA HEALTH AND REHAB AT REEDS COVE			STREET ADDRESS, CITY, STATE, ZIP CODE 2114 N 127TH CT EAST WICHITA, KS 67228		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 323	<p>Continued From page 9</p> <p>9/30/14 revealed a BIMS score of 12 (moderate cognitive impairment), required extensive assist of 1 with transfers, bed mobility and toileting. The MDS revealed the resident did not walk during the past 7 days and did not have any falls since prior assessment.</p> <p>Review of resident #22's care plan reviewed on 3/7/14 revealed the resident was at risk for falls with actual falls. It directed staff to assess fall risk per facility policy and assist with wheelchair locomotion on and off unit. It also included hand written updates dated 3-6-14 included education provided to the resident, family, and therapy to wait for staff for help when walking or transferring, toileting after meals, and to remind the resident to wear appropriate foot wear when out of bed. It also indicated the resident was unable to walk and required extensive assistance of 1 staff for locomotion on and off the unit. The care plan lacked revision to indicate the resident was on a walk to dine program.</p> <p>Review of the care plan last reviewed on 5/12/15 identified the resident was at risk for falls and had a history of falls directed staff to assist to ambulate to meals as tolerated, assist the resident with bed mobility and transfers as necessary. It directed staff to assist the resident with bed mobility, transfers, and locomotion on and off unit. It also revealed the resident required extensive assist of 1 staff to walk in room/corridor, total assist of 1 for locomotion on/off unit, and extensive assist of 1 for toilet use. The care plan lacked direction if staff needed to use a gait belt for walking.</p> <p>Review of the fall investigation dated 8/25/14 revealed the resident had a fall on 8/10/14 at 1:05</p>	F 323			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/21/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175532	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/21/2015
NAME OF PROVIDER OR SUPPLIER AVITA HEALTH AND REHAB AT REEDS COVE			STREET ADDRESS, CITY, STATE, ZIP CODE 2114 N 127TH CT EAST WICHITA, KS 67228		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 323	<p>Continued From page 10</p> <p>PM. Direct care staff Z assisted the resident to walk from the dining room back to his/her room. Staff Z reported he/she pushed the resident's wheelchair behind him/her while the resident walked pushing his/her front wheeled walker and wore a gait belt. Direct care staff Z stated he/she did not have hold of the gait belt to help stabilize the resident and could not get to the resident in time when the resident lost his/her balance. The resident was sent to the hospital for evaluation and the x-ray report revealed the resident had a pelvic fracture. During the investigation it was determined that the resident required extensive assistance from one staff with walking. On 5-26-14 therapy instructed staff to "walk to dine" (walk the resident back and forth to meals), using a gait belt and a front wheeled walker with 1 staff assistance.</p> <p>Review of the staff Z's witness statements revealed he/she assisted the resident back to his/her room. The resident walked pushing his/her front wheeled walker and wore the gait belt and staff Z followed behind the resident pushing the wheelchair in case the resident lost his/her balance. The resident took a couple of steps and lost his/her balance, fell to the floor and hit his/her head.</p> <p>Observation on 5/13/15 at 11:45 AM revealed resident #22 ambulated to the dining area for the noon meal with use of a walker and a staff member walking beside him/her holding onto the gait belt. The resident had a steady gait as he/she walked.</p> <p>Observation on 5/14/15 at 7:05 AM revealed direct care staff FF ambulated the resident with use of a gait belt and walker. The resident's gait</p>	F 323			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/21/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175532	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/21/2015
NAME OF PROVIDER OR SUPPLIER AVITA HEALTH AND REHAB AT REEDS COVE			STREET ADDRESS, CITY, STATE, ZIP CODE 2114 N 127TH CT EAST WICHITA, KS 67228		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 323	Continued From page 11 was steady. When the resident reached the dining table the resident then sat in a wheelchair for the morning meal. During an interview on 5/14/15 at 8:00 AM direct care staff FF reported the resident was a walk to dine, but staff assisted him/her into the wheelchair so the resident could go to the bathroom right after he/she finished eating. During an interview on 5-14-15 at 5:10 PM Administrative staff A and Consultant staff BB stated based on the investigation direct care staff did not understand the meaning of "stand by assistance" when they walked the resident. They determined the facility needed to provide a facility wide education regarding "stand by assistance" and "contact guard" assistance. Staff BB stated the staff should have had hold of the gait belt while walking the resident. Review of the facilities transfer definitions revealed Stand By Assistance indicated the resident required a gait belt on, staff member next to the resident for safety and the staff needed to be ready to grab gait belt and assist if needed. The definition for Contact Guard the resident required a gait belt and staff holding gait belt for safety. The facility failed to ensure staff provided care as planned for resident #22 who had a fall with a pelvic fracture.	F 323			
F 325 SS=G	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a	F 325			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/21/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175532	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/21/2015
NAME OF PROVIDER OR SUPPLIER AVITA HEALTH AND REHAB AT REEDS COVE			STREET ADDRESS, CITY, STATE, ZIP CODE 2114 N 127TH CT EAST WICHITA, KS 67228		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 325	<p>Continued From page 12</p> <p>resident -</p> <p>(1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and</p> <p>(2) Receives a therapeutic diet when there is a nutritional problem.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>The facility census totaled 69 residents with 27 residents sampled with 4 residents reviewed for nutrition. Based on observation, interview, and record review the facility failed to ensure staff provided nutritional supplements for 1 of 4 residents sampled for weight loss. Resident #107 experienced a severe weight loss.</p> <p>Findings included:</p> <ul style="list-style-type: none"> - Review of resident #107's physician order sheet dated 5-8-15 included the following diagnoses: muscle weakness and protein-calorie malnutrition. <p>Review of the significant change MDS (minimum data set, a required assessment) dated 11-26-14 revealed the resident had short and long term memory problems with moderately impaired decision making ability. The resident required total assistance of 1 staff with eating and had swallowing problems identified by coughing/choking during meals. The MDS also identified the resident had weight loss and was not on a prescribed weight loss regimen.</p>	F 325			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/21/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175532	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/21/2015
NAME OF PROVIDER OR SUPPLIER AVITA HEALTH AND REHAB AT REEDS COVE			STREET ADDRESS, CITY, STATE, ZIP CODE 2114 N 127TH CT EAST WICHITA, KS 67228		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 325	<p>Continued From page 13</p> <p>Review of the ADL (activities of daily living) CAA (care area assessment) dated 12-8-14 indicated the resident had impaired function noted since his/her decline in status and was dependent on staff for eating. The Nutritional CAA revealed the resident had actual weight loss, received a mechanically altered diet with enhanced foods, and was dependent on staff for oral intake. The registered dietitian monitored the resident's weight loss and intake.</p> <p>Review of the quarterly MDS dated 4-16-15 revealed the resident had short and long term memory deficit with moderately impaired decision making ability. It also revealed the resident required extensive assistance of 1 with eating, had swallowing problems, had a significant weight loss and was not on a prescribed weight loss regimen.</p> <p>Review of resident #107's care plan last reviewed on 4-28-15 revealed the resident had a nutritional problem related to poor meal intake. The care plan included the following interventions: Cue to double swallow between bites and drinks, dependent on staff for oral intake, dietician to monitor and suggest intervention for continued weight loss, high calorie snacks between meals, Magic Cup as ordered, and med pass (a liquid nutritional supplement) as ordered. The care plan also directed staff to offer high caloric hot chocolate prepared with half and half at breakfast and PRN (as needed). The care plan directed staff to monitor intake and offer favorite foods such as pancakes when oral intake was poor and super cereal as ordered.</p> <p>Review of the care plan conference summary dated 4-28-15 identified the resident had current</p>	F 325			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/21/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175532	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/21/2015
NAME OF PROVIDER OR SUPPLIER AVITA HEALTH AND REHAB AT REEDS COVE			STREET ADDRESS, CITY, STATE, ZIP CODE 2114 N 127TH CT EAST WICHITA, KS 67228		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 325	<p>Continued From page 14</p> <p>weight loss and staff reviewed the plan of care.</p> <p>Review of the physician's orders dated 5-8-15 included the following: On 10-28-14 supercereal with breakfast ordered after a weight loss of 11 pounds (9.4%) in 19 days. On 11-11-14 magic cup three times a day with meals ordered after the resident continued to lose 6 more pounds. On 11-24-14 High calorie snacks between meals was ordered after the resident had gained 3 pounds. On 12-2-14 - Med pass 2.0 30 ml (millimeters) four times a day was ordered after the resident lost 2 more pounds for a total of 16 pounds or 14% loss in 2 months. On 4-20-15 Offer high calories hot chocolate prepared with half and half at breakfast and PRN (as needed) was ordered after the resident 3 pounds for a total of 19.9 pounds.</p> <p>Review of resident #107's weight records revealed the following weight loss: 10-2-14 the resident weighed 114.2# (pounds) and on 11-7-14 the resident weighted 99# which indicated a 13.35# weight loss in 1 month.</p> <p>On 4-2-15 the resident weighed 90.8#, a 20.4% loss in 6 months.</p> <p>On 5-5-15 the resident weighted 88.4# a severe weight loss of 25.8# in 7 months.</p> <p>Review of the dietitian progress notes revealed the following: The 10/12/2014 dietitian note revealed the resident received a mechanical soft, ground meat with gravy diet. It identified the resident liked</p>	F 325			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/21/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175532	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/21/2015
NAME OF PROVIDER OR SUPPLIER AVITA HEALTH AND REHAB AT REEDS COVE			STREET ADDRESS, CITY, STATE, ZIP CODE 2114 N 127TH CT EAST WICHITA, KS 67228		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 325	<p>Continued From page 15</p> <p>turkey bacon, and pancakes, and received health shake twice a day between meals.</p> <p>On 10/23/2014 dietitian note revealed the resident had a diet with pureed texture, with nectar consistency fluids. It identified the resident did not like pureed texture foods. The staff assists as needed to help in feeding and cueing. Resident ate 50% or less of his/her meals.</p> <p>A dietary note dated 10/29/2014 revealed the resident's diet had been upgraded to mechanical soft with puree meats, and the resident may have regular pancakes.</p> <p>The 11/3/2014 dietitian notes revealed the resident received magic cup twice a day with lunch and supper. The resident refused super cereal at breakfast and liked pancakes with gravy. The dietitian requested staff to add half-and-half cream to the resident's pancakes. It revealed that staff would offer the resident pancakes for lunch and supper also. The resident continued to have poor meal intake and ate less than 25% of meals.</p> <p>The 12/1/2014 dietitian note revealed the resident had a significant weight loss in the past 3 months. The resident had a current diet of pureed foods with mechanical soft pleasure foods allowed (foods the resident liked); enhanced foods, magic cup three times a day with meals and between meals and high calorie snacks between meals. The resident received feeding assistance by staff and received medications (Remeron and Megace) to stimulate his/her appetite.</p> <p>A dietary manager note on 12/7/2014 revealed the dietitian recommended on 12/1/14 to add</p>	F 325			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/21/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175532	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/21/2015
NAME OF PROVIDER OR SUPPLIER AVITA HEALTH AND REHAB AT REEDS COVE			STREET ADDRESS, CITY, STATE, ZIP CODE 2114 N 127TH CT EAST WICHITA, KS 67228		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 325	<p>Continued From page 16</p> <p>med pass (a type of liquid supplement) 30 cc. four times a day.</p> <p>Dietitians note dated 12/15/2014 revealed staff reported breakfast was the resident's best meal but the resident still refused meals and alternates. The staff met with the resident's family and the decision not to place a feeding tube for nutrition was made.</p> <p>A dietary note dated 1/26/2015 revealed the resident's diet changed to regular texture per family.</p> <p>On 2/15/2015 a dietitian note revealed the dietitian observed the resident eat the noon meal on 2/14/15 and the resident fed him/herself using his/her fingers and did not want staff to help.</p> <p>A dietitian note dated 3/30/2015 revealed the resident weighed 93.2# on 3/26/15 which reflected a 15.4% significant weight loss in 6 months.</p> <p>On 4/3/2015 a dietitian note revealed the resident weighed 90.8#; and received a regular, mechanical soft pleasure food diet. The resident also received magic cup three times a day and Remeron for an appetite stimulant. The resident weight loss revealed 18.7% in 6 months and weight loss of 8.1% in 3 months.</p> <p>On 4/27/2015 a dietitian note revealed the residents current weight of 90# reflected a significant loss of 12.9% in 6 months.</p> <p>A dietitian note dated 5/11/2015 revealed the residents current weight of 88.4# reflected a significant weight loss of 10.7% in 3 month and</p>	F 325			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/21/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175532	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/21/2015
NAME OF PROVIDER OR SUPPLIER AVITA HEALTH AND REHAB AT REEDS COVE			STREET ADDRESS, CITY, STATE, ZIP CODE 2114 N 127TH CT EAST WICHITA, KS 67228		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 325	<p>Continued From page 17</p> <p>an 11.2% loss in 6 months. the resident received a regular, diet with the following supplements: High calorie hot chocolate at breakfast, High calorie snacks between meals, Med Pass 2.0 30 cc four times a day, Magic cup three times a day with meals, and enhanced pancakes when served. The resident continues to lose weight.</p> <p>Observation on 5/11/15 at 11:50 AM resident #107 sat at the raised table for lunch with a visitor. The resident had a piece of chicken in his/her right hand and was slowly eating it. At 12:23 PM the resident just sat in the chair with his/her eyes closed - staff was able to wake him/her up and he/she continued to eat. At 12:58 PM another visitor came and sat beside the resident and tried to cue the resident to eat the chicken. The direct care staff brought the resident a cup that had a shake/supplement and the visitor gave the resident a few drinks but the resident did not want any more. The resident did not get the magic cup as ordered.</p> <p>5/12/2015 at 8:00 AM the resident sat at the breakfast table with his/her head in his/her hand and pancakes on the plate in front of him/her. At 8:25 AM a visitor came in to visit the resident and helped the resident eat the pancake, 25 minutes after staff served the resident. The resident ate 75% of the meal. Staff took the resident back to his/her room without providing the resident supercereal, magic cup, or hot chocolate with half and half as ordered.</p> <p>Observation on 5/13/15 at 8:30 AM revealed staff served the resident pancakes and bacon and a glass of orange juice. At 8:55 AM staff removed the resident's plate and the resident ate 75% of the pancakes and all of the bacon. At 9:20 AM</p>	F 325			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/21/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175532	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/21/2015
NAME OF PROVIDER OR SUPPLIER AVITA HEALTH AND REHAB AT REEDS COVE			STREET ADDRESS, CITY, STATE, ZIP CODE 2114 N 127TH CT EAST WICHITA, KS 67228		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 325	<p>Continued From page 18</p> <p>staff took the resident back to his/her room without offering him/her the supercereal, magic cup, or the hot chocolate with half and half as ordered.</p> <p>Observation on 5/13/14 staff brought the resident to the table at 11:32 AM. At 12:33 PM, (1 hour and 1 minute later) staff served the resident a grilled cheese sandwich and a cup of water. At 12:49 PM direct care staff Q took the resident a piece of coconut cream pie and gave him/her a bite. At 1:46 PM direct care staff Q and P assisted the resident from the table and into his/her bed. The resident was taken from the table and did not receive the magic cup as ordered.</p> <p>Observation on 5/14/2015 at 8:18 AM staff served resident #107 a plate with pancakes and bacon and had a bowl of oatmeal. At 8:51 AM the resident ate 50% of his/her pancakes and started eating the supercereal. At 9:42 AM Dietary staff M gave the resident a magic cup, ice cream which he/she ate 100% and also ate 90% of his/her super cereal. The staff failed to serve the resident his/her hot chocolate shake made with half and half as ordered.</p> <p>5/14/2015 at 10:15 AM observation of the electronic MAR (medication administration record) revealed the resident had not received his/her med pass supplement, the magic cup, or the hot choc shake yet. At 10:18 AM direct care staff Q administered the resident his/her medications. Staff Q did not take any med pass (liquid supplement) with him/her when he/she gave the resident the medications as ordered. At 10:20 AM the electronic MAR indicated the resident received his/her magic cup, hot cocoa shake, and</p>	F 325			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/21/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175532	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/21/2015
NAME OF PROVIDER OR SUPPLIER AVITA HEALTH AND REHAB AT REEDS COVE			STREET ADDRESS, CITY, STATE, ZIP CODE 2114 N 127TH CT EAST WICHITA, KS 67228		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 325	<p>Continued From page 19 med pass.</p> <p>An interview on 5/14/15 at 10:22 AM direct care staff Q stated he/she gave the med pass to the resident with his/her magic cup. (Observations revealed the dietary manager gave the resident the magic cup and staff Q did not add any med pass to it.) The staff Q then stated he/she put it in the chocolate drink he/she gave the resident and when informed the resident did not get a chocolate drink staff Q stated he/she would have to check on the med pass.</p> <p>During an interview on 05/14/2015 at 8:19 AM dietary staff V stated staff were supposed to serve the resident supercereal with breakfast every morning according to the dietary information.</p> <p>During an interview on 5/14/15 at 10:30 AM direct care staff P stated the amount of assistance the staff provided the resident varied each meal because the resident liked to do it him/herself if possible. Staff P stated that each of the direct care staff had to remind each other to give the resident his/her supercereal and shakes. He/she stated the resident had problems with weight loss in the past.</p> <p>During an interview on 5/14/15 at 2:45 PM dietary staff M stated the staff needed to give the resident the supercereal so that it was on the table and the resident could eat it if he/she wanted to. Staff M stated if the staff had not given the resident his/her supplements then weight loss would continue.</p> <p>During an interview on 5/14/15 at 11:22 AM licensed nursing staff R stated supplement</p>	F 325			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/21/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175532	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/21/2015
NAME OF PROVIDER OR SUPPLIER AVITA HEALTH AND REHAB AT REEDS COVE			STREET ADDRESS, CITY, STATE, ZIP CODE 2114 N 127TH CT EAST WICHITA, KS 67228		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 325	Continued From page 20 administration showed up on the medication administration record and if staff documented the supplement was given he/she assumed it was. Staff R stated it was the nurse aide's responsibility to pass the supplements and make the shakes. During an interview on 5/14/15 at 11:34 AM administrative nursing staff T stated the direct care staff and dietary staff were supposed to offer the resident the supplements. Staff T stated if the documentation was not accurate he/she would not know, he/she did not have time to sit and watch a meal service. Staff T also stated he/she would expect the care plan to accurately reflect the needs of the resident, including his/her ability to feed self independently. The facility failed to provide nutritional supplements as ordered for resident #107 who experienced severe weight loss.	F 325			
F 333 SS=G	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: The facility had a census of 69 residents 27 selected for sample and 6 residents reviewed for unnecessary medications. Based on interview and record review, the facility failed to ensure 1 of 6 sampled residents remained free of significant medications errors. (#182) Findings included:	F 333			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/21/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175532	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/21/2015
NAME OF PROVIDER OR SUPPLIER AVITA HEALTH AND REHAB AT REEDS COVE			STREET ADDRESS, CITY, STATE, ZIP CODE 2114 N 127TH CT EAST WICHITA, KS 67228		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 333	<p>Continued From page 21</p> <p>-Resident #182's 10/24/15 admission physician orders included orders for Tamsulosin 0.4 mg (milligrams) daily for difficult urination, Lasix 40 mg daily for swelling, Hydralazine 50 mg twice daily for blood pressure, Metoprolol 100 mg daily for blood pressure, Allopurinol 300 mg daily for gout (build up of uric acid), Isosorbide ER (extended release) 60 mg daily for angina (chest pain), and Simvastatin 20 mg daily for elevated cholesterol levels.</p> <p>Resident #182's 10/30/15 admission MDS (minimum data set) assessment revealed the resident had a BIMS (brief interview for mental status) score of 15, which indicated intact cognition. The assessment also indicated the resident required limited assistance of 1 person for transfers and toilet use. He/she required extensive assistance of 1 person for dressing and personal hygiene. The resident received scheduled and as needed pain medications for moderate pain that did not interfere with sleep or day to day activities. The assessment also revealed the resident received diuretic therapy (medications given to promote production of urine and decrease swelling) for 7 days of the assessment period.</p> <p>Resident #182's 10/30/14 CAAs (care area assessment) lacked an analysis of findings for the triggered care areas.</p> <p>The resident's 11/14/14 care plan directed staff to administer all medications as ordered.</p> <p>A progress note written by Nurse Practitioner C dated 10/29/14 stated the resident had CAD (coronary heart disease) and recommended</p>	F 333			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/21/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175532	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/21/2015
NAME OF PROVIDER OR SUPPLIER AVITA HEALTH AND REHAB AT REEDS COVE			STREET ADDRESS, CITY, STATE, ZIP CODE 2114 N 127TH CT EAST WICHITA, KS 67228		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 333	<p>Continued From page 22 continuation of current medications.</p> <p>An 11/3/14 physician progress note indicated the resident had bilateral 1+ edema (rating scale for severity of swelling, indicating mild swelling of the lower extremities). The note also documented the resident had hypertension (elevated blood pressure) and renal insufficiency (kidney disease) and noted the resident received Hydralazine, Lisinopril, and Metoprolol (all medications to lower the blood pressure).</p> <p>A physician progress note dated 11/6/14 revealed the resident had 1+ generalized edema and decreased lung sounds in the bases of the lungs. The note indicated the resident received multiple blood pressure medications, including Lasix. The resident's condition was stable and Nurse Practitioner C recommended he/she continue with the current medication regimen.</p> <p>Nurse Practitioner C's progress note dated 11/7/14 indicated the resident was short of breath with exertion and the resident stated it was no worse than usual. The resident wore continuous oxygen.</p> <p>A physician progress note dated 11/10/14 stated the resident was not short of breath, but had 2+ edema (rating scale for severity of swelling, indicating moderate swelling of the lower extremities).</p> <p>A physician progress note dated 11/12/14 revealed the resident had a chest x-ray that indicated he/she had cardiomegaly (enlarged heart) with rather severe chronic pulmonary (lung) changes, no definite acute inflammatory infiltrates or pneumonia. A new order was given</p>	F 333			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/21/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175532	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/21/2015
NAME OF PROVIDER OR SUPPLIER AVITA HEALTH AND REHAB AT REEDS COVE			STREET ADDRESS, CITY, STATE, ZIP CODE 2114 N 127TH CT EAST WICHITA, KS 67228		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 333	<p>Continued From page 23</p> <p>for an Albuterol breathing treatment three times a day.</p> <p>An 11/13/14 physician progress note stated the resident continued with occasional dyspnea (difficulty breathing) and ordered Pulmicort twice a day with the Albuterol breathing treatments.</p> <p>A physician's order dated 11/13/14 added Pulmicort suspension for inhalation to the resident's medication regimen.</p> <p>A physician's order dated 11/16/14 added Albuterol breathing treatments every 4 hours as needed for shortness of breath, in addition to the scheduled breathing treatments.</p> <p>Nurses' notes dated 11/17/14 at 3:30 p.m. stated the resident went to an appointment with his/her cardiologist, who admitted the resident to a local hospital.</p> <p>Office notes from the visit with the cardiologist on 11/17/14 revealed the resident had diagnoses of CAD, AF (atrial fibrillation, irregular heart rhythm), acute CHF (congestive heart failure), dyslipidemia (elevated lipid/fat levels in the blood), and hypertension. Treatment for the diagnosis of acute CHF included hospital admission for "acute on chronic CHF". According to the note the resident had 3+ edema (rating scale for severity of swelling, indicating deep indention that remains for a short period of time and extremities look swollen).</p> <p>Resident #182's 11/17/14 admission history and physical from the local hospital identified the resident's chief complaint as shortness of breath and dyspnea. The resident complained of more</p>	F 333			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/21/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175532	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/21/2015
NAME OF PROVIDER OR SUPPLIER AVITA HEALTH AND REHAB AT REEDS COVE			STREET ADDRESS, CITY, STATE, ZIP CODE 2114 N 127TH CT EAST WICHITA, KS 67228		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 333	<p>Continued From page 24</p> <p>shortness of breath that worsened in the past week prior to admission with increased leg edema. The resident was in acute heart failure and required admission to the hospital for further evaluation and treatment. The list of home medications at the time admission included Lasix 40 mg daily. The physical exam revealed the resident had decreased breath sounds at the bases and 3+ edema in both extremities. The treatment plan included IV (intravenous) diuresis for the congestive heart failure.</p> <p>Review of resident #182's November 2014 MAR (medication administration record) revealed staff marked the following medications as "8" which indicated the medication was unavailable and not administered:</p> <p>*Allopurinol for Gout (excess uric acid in joint) 11/9/14-11/17/14 (9 days)</p> <p>*Lasix for diuresis (remove excess fluid) 11/10/14-11/17/14 (8 days, the week prior to admission to the hospital)</p> <p>*Isosorbide ER for angina (chest pain) 11/11/14-11/17/14 (7 days)</p> <p>*Metoprolol for blood pressure 11/10/14-11/14/14 (5 days)</p> <p>*Simvastatin for hyperlipidemia 11/15/14-11/16/14 (2 days)</p> <p>*Tamsulosin for difficult urination 11/9/14-11/17/14 (9 days)</p> <p>*Hydralazine for blood pressure 11/10/14-11/17/14 (unavailable 11 times, space blank 2 times, and administered once during this time frame)</p> <p>*Budesonide for shortness of breath 11/14/14-11/15/14 (2 days)</p> <p>Review of resident #182's clinical record lacked documentation in the nurses' notes that the</p>	F 333			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/21/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175532	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/21/2015
NAME OF PROVIDER OR SUPPLIER AVITA HEALTH AND REHAB AT REEDS COVE			STREET ADDRESS, CITY, STATE, ZIP CODE 2114 N 127TH CT EAST WICHITA, KS 67228		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 333	<p>Continued From page 25</p> <p>resident did not receive the above ordered medications.</p> <p>Resident #182 no longer resided in the facility and was unavailable for observations.</p> <p>According to the facility's investigation, direct care staff U passed medications on 11/10/14, 11/11/14, 11/14/14, and 11/17/14. Staff U was aware the Lasix for the resident was not in the medication cart on the days he/she worked. On 11/12/14, 11/13/14, 11/15/14, and 11/16/14, direct care staff W passed medications and was aware that the resident's Lasix was not in the medication cart. The results of the facility investigation revealed the root cause of the reason for the medication omissions was due to the CMAs (certified medication aides, staff U and W) not reporting to the charge nurse when resident #182's medications were unavailable and also failed to follow the facility's policy for reordering medications.</p> <p>During an interview on 5/14/15 at 8:45 a.m., direct care staff X confirmed that if medications were unavailable, staff marked an "8" on the MAR.</p> <p>During an interview on 5/14/15 at 3:00 p.m., licensed nurse Y stated that if a medication was not available, he/she would first check the cart to ensure the medication was not misplaced. Then he/she would contact the pharmacy to verify they received the medication order or refill order. Nurse Y stated the pharmacy can review their records to see if they delivered the medication and who signed for it. Nurse Y also verified the facility's E-kit contained Lasix and this could be used until the facility received the medication</p>	F 333			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/21/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175532	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/21/2015
NAME OF PROVIDER OR SUPPLIER AVITA HEALTH AND REHAB AT REEDS COVE			STREET ADDRESS, CITY, STATE, ZIP CODE 2114 N 127TH CT EAST WICHITA, KS 67228		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 333	<p>Continued From page 26</p> <p>from the pharmacy to prevent the resident from missing a dose.</p> <p>An interview on 5/14/15 at 1:13 p.m. with Nurse Practitioner C revealed he/she monitored resident #182's condition during the week prior to his/her admission to the hospital. Nurse C stated he/she was unaware the resident did not receive all of his/her ordered medications. According to Nurse Practitioner C, the omission of the resident's Lasix probably contributed to the exacerbation of his/her congestive heart failure. Nurse C thought the resident received the Lasix during that time and confirmed his/her dyspnea gradually worsened.</p> <p>During an interview on 5/14/15 at 4:00 p.m., administrative nurse B confirmed resident #182 did not receive his/her medications as ordered, including the Lasix. Nurse B stated he/she immediately investigated the incident for causative factors and suspended the staff involved pending the results of the investigation.</p> <p>The facility's revised 1/1/13 Medication Shortage/Unavailable Medication Policy directed staff to immediately initiate action to obtain medications when they identify an inadequate supply. If the discovery occurred during normal hours, the nurse should call the pharmacy to determine the status of the order. If the next available delivery causes delay or a missed dose in the resident's medication schedule, the nurse should obtain the medication from the emergency medication supply. Facility staff should notify the pharmacy and arrange for an emergency delivery. If discovered after normal pharmacy hours, the nurse should obtain the medication from the emergency medication supply and call the</p>	F 333			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/21/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175532	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/21/2015
NAME OF PROVIDER OR SUPPLIER AVITA HEALTH AND REHAB AT REEDS COVE			STREET ADDRESS, CITY, STATE, ZIP CODE 2114 N 127TH CT EAST WICHITA, KS 67228		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 333	Continued From page 27 pharmacy emergency answering service. If an emergency delivery is unavailable, the nurse should contact the attending physician to obtain orders or directions. When a missed dose is unavoidable, the nurse should document the missed dose and an explanation for the missed dose on the MAR/TAR (treatment administration record) and in the nurses' notes. The facility failed to ensure resident #182 remained free from a significant medication error when facility staff failed to ensure the resident received his/her ordered medications. Facility staff failed to administer resident #182's Lasix for 8 days. The resident required hospitalization for acute on chronic congestive heart failure that required intravenous diuretic therapy.	F 333			
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: The facility census totaled 69 residents. Based on observation, interview, and record review the facility failed to store food, prepare food in a sanitary manner in one kitchen of four and failed to maintain clean equipment to prepare food in 4	F 371			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/21/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175532	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/21/2015
NAME OF PROVIDER OR SUPPLIER AVITA HEALTH AND REHAB AT REEDS COVE			STREET ADDRESS, CITY, STATE, ZIP CODE 2114 N 127TH CT EAST WICHITA, KS 67228		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 371	<p>Continued From page 28</p> <p>of 4 kitchens. This had the potential to affect all residents served from those 4 kitchens.</p> <p>Findings included:</p> <ul style="list-style-type: none"> - During initial tour of the facility on 5/11/15 at 7:15 a.m., a large opened, undated bag of frozen garlic bread was in the freezer between Riffle House and Sagnbene house which had adjoining kitchens. Dietary staff M removed the food item. <p>Observation of the oven in Sagnbene house kitchen on 5/13/15 at 11:45 a.m. revealed cooked food debris on the door of the oven and in the oven. The oven had aluminum foil stuck to the bottom of the oven with burnt food.</p> <p>During observation on 5/13/15 at 11:40 a.m. in the Sagnbene house kitchen dietary staff F finished preparing food and proceeded to take food temperatures of the food on the steam table prior to serving. Staff F picked a thermometer up from a soiled countertop and without cleaning the thermometer stuck it into the pan of beef tips. He/she then removed it, cleaned it with an alcohol pad and took the temperature of the vegetables and the starch. Dietary staff F then laid the thermometer with no cover back onto the counter. Dietary staff F then placed the pureed food from the oven onto the steam table. Staff F again picked up the thermometer off the counter and without cleaning it placed it into the pan of pureed food and placed back on counter. Several times during food prep and service staff F reached up and adjusted his/her hair and hair net. The hair net was large and kept slipping down into staff F's face. Staff F did not wash hands after adjusting the hairnet.</p>	F 371			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/21/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175532	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/21/2015
NAME OF PROVIDER OR SUPPLIER AVITA HEALTH AND REHAB AT REEDS COVE			STREET ADDRESS, CITY, STATE, ZIP CODE 2114 N 127TH CT EAST WICHITA, KS 67228		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 371	<p>Continued From page 29</p> <p>During an interview on 5/11/15 at 7:30 a.m. dietary staff M reported the staff received inservice training on the proper storage and dating of food items.</p> <p>During an interview on 5/13/15 at 12:20 p.m. dietary staff F reported the hair nets were too big to stay in place and always slid down. The staff also reported using alcohol wipes should be used to clean the thermometer. Staff F reported the kitchen had a cleaning schedule but did not know how often staff cleaned the oven.</p> <p>During an interview at 12:40 p.m. dietary staff M reported the ovens should be cleaned monthly then if a cook spilled anything in the oven it was their responsibility to clean the food up. Dietary staff produced cleaning schedules showing cleaning of the oven 4/5/15 and 5/5/15. Staff M reported he/she was cleaning the oven today and will schedule cleaning for every other week instead of monthly as before.</p> <p>Review of the policy for food preparation and handling dated 4/21/13 revealed:</p> <p>*The kitchen and equipment will be kept clean, neat, orderly and well maintained.</p> <p>*Any food handlers will perform hand hygiene (hand washing) regularly on a designated sink during each shift and in particular after touching ears, nose, mouth or hair and before handling ay food or equipment.</p> <p>The facility failed to store and prepare food in a sanitary manner by having unmarked open food items in the freezer, lack of appropriate hand hygiene, and not properly cleaning the</p>	F 371			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/21/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175532	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/21/2015
NAME OF PROVIDER OR SUPPLIER AVITA HEALTH AND REHAB AT REEDS COVE			STREET ADDRESS, CITY, STATE, ZIP CODE 2114 N 127TH CT EAST WICHITA, KS 67228		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 371	<p>Continued From page 30</p> <p>thermometer used to obtain temperatures of foods served.</p> <p>- During observation on 5/13/15 at 11:52 a.m., the 300 hall kitchen revealed the refrigerator had a red substance down the right side and on the top of the bottom shelf. The freezer door had spots of spillage on it, and the left side of the freezer had spillage of an orange substance.</p> <p>Observation 05/13/2015 at 2:58 p.m. of the 300 kitchen revealed the pots had grease build up on the outside of the pan and had rings of buildup on the inside. The skillets had a large amount of black build up on the outside and inside where only a portion of the bottom of the skillet was silver colored.</p> <p>Observation on 5/13/15 at 3:05 p.m. of the 400 kitchen revealed the skillets had a large amount of black build up on both the outside and inside. The rubber handles on 2 of the skillets had splits and in poor condition to where the handles could not be cleaned thoroughly.</p> <p>Observation on 5/13/15 at 12:00 p.m. of the Riffel House Kitchen revealed baked on black grease coating 2 skillets on most of the inside and outside. The toaster had a burnt substance on the outside. A 12 cup muffin pan had grease build up on it in the cups, lip, and backside. One 17.5 x 11.5 x1" cookie sheet missing the non-stick surface with rust spots on the cooking surface. Two pans for the steam table had yellow sticky substance on the outside of the pans. One 6" deep 1/2 steam pan had green food particle on outside.</p>	F 371			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/21/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175532		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/21/2015	
NAME OF PROVIDER OR SUPPLIER AVITA HEALTH AND REHAB AT REEDS COVE				STREET ADDRESS, CITY, STATE, ZIP CODE 2114 N 127TH CT EAST WICHITA, KS 67228			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 371	<p>Continued From page 31</p> <p>During an interview 05/13/2015 at 12:38: p.m., dietary staff M reported that he/she didn't think the cookie sheets and steam pans were clean. Staff M stated the dishwashers were too small to accept the large cookware. The sinks are also too small to clean by hand. Pans could be taken to the bistro to be cleaned in the sinks there.</p> <p>During an interview on 05/13/2015 12:16 p.m. dietary staff CC said it was not acceptable and he/she tried to clean the pans as he/she used them.</p> <p>During an interview 05/13/2015 at 12:38: p.m., dietary staff M reported that he/she didn't think the cookie sheets and steam pans were clean. Staff M stated the dishwashers were too small to accept the large cookware. The sinks are also too small to clean by hand. Pans could be taken to the bistro to be cleaned in the sinks there.</p> <p>During an interview on 5/13/15 at 2:50 p.m., AA stated that they wash them and run them through the dishwasher but they did not look clean.</p> <p>During an interview on 5-13-15 at 3:00 dietary staff M stated that the pans were old and had grease build up from over the years. He/she stated that they used the brillo pad to clean them and then wash them in the dishwasher. Staff M thought they would have to start bringing them to the bigger sink area in the Bistro which had a triple sink.</p> <p>Review of the policy for food preparation and handling dated 4/21/13 revealed: The kitchen and equipment will be kept clean, neat, orderly and well maintained.</p>			F 371			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/21/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175532	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/21/2015
NAME OF PROVIDER OR SUPPLIER AVITA HEALTH AND REHAB AT REEDS COVE			STREET ADDRESS, CITY, STATE, ZIP CODE 2114 N 127TH CT EAST WICHITA, KS 67228		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 371	Continued From page 32 Review of the undated cleaning equipment policy for dietary services revealed Pans should be filled with water and detergent and soaked to loosen soil, hot water for greasy pans. Pots and pans should be washed in the three compartment sink using hot, soapy water in the first compartment. A nylon brush or metal sponge should be used to scrub all pots, pans and utensils. A wire brush should be used around where the handle is attached to prevent buildup of grease. The facility failed to prepare food in a sanitary manner by using cookware with grease build-up on the outside and inside of the pans. The facility also failed to keep the refrigerator and freezer clean.	F 371			
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to	F 441			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/21/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175532	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/21/2015
NAME OF PROVIDER OR SUPPLIER AVITA HEALTH AND REHAB AT REEDS COVE			STREET ADDRESS, CITY, STATE, ZIP CODE 2114 N 127TH CT EAST WICHITA, KS 67228		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 441	<p>Continued From page 33</p> <p>prevent the spread of infection, the facility must isolate the resident.</p> <p>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: The facility reported a census of 69 residents. Based on observation and interview the facility failed to provide a safe and sanitary environment to help prevent the development and transmission of diseases and infections by failure to use chemicals for cleaning of an isolation room for C-Difficile (a contagious bacteria characterized by diarrhea) in the facility.</p> <p>Findings included:</p> <ul style="list-style-type: none"> - During an observation on 5/13/15 at 9:09 a.m., housekeeping staff O entered an isolation room wearing a gown, gloves, and a mask. The facility placed the resident on isolation precautions for C-Difficile. At 0915 he/she sprayed the sink and toilet with Virasept (a ready-to-use, "one-step" detergent-disinfectant, virucide, bactericide, tuberculocide, fungicide and sporicide that 	F 441			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/21/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175532	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/21/2015
NAME OF PROVIDER OR SUPPLIER AVITA HEALTH AND REHAB AT REEDS COVE			STREET ADDRESS, CITY, STATE, ZIP CODE 2114 N 127TH CT EAST WICHITA, KS 67228		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 441	<p>Continued From page 34</p> <p>effectively cleans and disinfects). According to manufacturer's information, the disinfectant used was effective against C-Difficle. Staff then used bleach saniwipes on all countertops, chairs, and doorknobs. Housekeeping staff O failed to wipe down the positioning bars on the resident's bed. Staff O wiped the shower and all handrails, sink, and counter top in the bathroom with bleach saniwipes. Staff O cleansed the toilet with bleach saniwipes from the exterior to the interior. Staff O mopped the tile bathroom floor with plain water and failed to vacuum the carpeted bedroom.</p> <p>On 5/13/15 at 9:25 a.m., housekeeping staff O verified the mop water was plain with no disinfectants or chemicals added. He/She also stated housekeeping staff did not vacuum the resident rooms.</p> <p>5/13/15 at 3:30 p.m. staff N stated that staff should use bleach (1 quart /4 gallons of water) in the water to mop the floors with in the isolation room. Staff N stated that staff did not vacuum this resident's room because of the isolation and he/she was trying to figure out some way to get a smaller vacuum device to use for isolation rooms. Housekeeping staff N confirmed this resident's room had not been vacuumed or disinfected properly.</p> <p>The facility failed to clean the positioning bars on a resident's bed that was in isolation. Housekeeping staff also failed to vacuum or use disinfectant cleaner to mop floors in an isolation room to prevent transmission of disease in the facility.</p>	F 441			